FOR OHF USE

LL I

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038281

Facility Name: HERITAGE MANOR-NORMAL

Address: 509 N. ADELAIDE (Number) NORMAL (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309) 452-7468 **Fax #** ( )

IDPA ID Number: 370909086004

Date of Initial License for Current Owners: 1979

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	59,860	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	59,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,210	23,227	1,408	50,845	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	26,210	23,227	1,408	50,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 84.94%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1979

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,408

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	27134	27134	0
IPA	26310	26310	0
medicare	1408	1408	0
	54852	54852	

IPA BEDHOLDS	100
PP BEDHOLDS	58
PP CONVERS	3849

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	323,931	22,795	0	346,726		346,726	5,069	351,795			1
2	Food Purchase		200,980		200,980		200,980	(1,139)	199,841			2
3	Housekeeping	108,462	35,373		143,835		143,835	0	143,835			3
4	Laundry	84,182	28,474		112,656		112,656	0	112,656			4
5	Heat and Other Utilities			142,706	142,706		142,706	2,064	144,770			5
6	Maintenance	130,552	70,696	33,875	235,123		235,123	16,261	251,384			6
7	Other (specify):*							0				7
8	TOTAL General Services	647,127	358,318	176,581	1,182,026		1,182,026	22,255	1,204,281			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250	0	3,250			9
10	Nursing and Medical Records	1,710,794	92,794	135,625	1,939,213		1,939,213	0	1,939,213			10
10a	Therapy		232,813	127,517	360,330	(466,608)	(106,278)	220,567	114,289			10a
11	Activities	51,893	3,157	0	55,050		55,050	0	55,050			11
12	Social Services	40,114	0	3,757	43,871		43,871	0	43,871			12
13	Nurse Aide Training	800	800		1,600		1,600	3,031	4,631			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,803,601	329,564	270,149	2,403,314	(466,608)	1,936,706	223,598	2,160,304			16
	C. General Administration											
17	Administrative	81,112			81,112		81,112	44,935	126,047			17
18	Directors Fees							7,037	7,037			18
19	Professional Services			386,255	386,255		386,255	(359,447)	26,808			19
20	Dues, Fees, Subscriptions & Promotions			128,953	128,953	(89,790)	39,163	(9,166)	29,997			20
21	Clerical & General Office Expense	243,551	15,254	13,244	272,049		272,049	243,985	516,034			21
22	Employee Benefits & Payroll Taxes			466,011	466,011		466,011	34,633	500,644			22
23	Inservice Training & Education			1,270	1,270		1,270	1,329	2,599			23
24	Travel and Seminar			3,807	3,807		3,807	(1,808)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			37,066	37,066		37,066	2,491	39,557			26
27	Other (specify):*			40,764	40,764		40,764	(40,722)	42			27
28	TOTAL General Administration	324,663	15,254	1,077,370	1,417,287	(89,790)	1,327,497	(76,733)	1,250,764			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,775,391	703,136	1,524,100	5,002,627	(556,398)	4,446,229	169,120	4,615,349			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			353,955	353,955		353,955	46,947	400,902			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			378,680	378,680		378,680	(452)	378,228			32
33	Real Estate Taxes			106,417	106,417		106,417	0	106,417			33
34	Rent-Facility & Grounds							11,649	11,649			34
35	Rent-Equipment & Vehicles			3,355	3,355		3,355	22,417	25,772			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			842,407	842,407		842,407	80,561	922,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					466,608	466,608	0	466,608			39
40	Barber and Beauty Shops	0	0	0				0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					89,790	89,790	0	89,790			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**					556,398	556,398		556,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,775,391	703,136	2,366,507	5,845,034	0	5,845,034	249,681	6,094,715			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,913)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	36,017	30		9
10	Interest and Other Investment Income	(312)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,139)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(787)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,254)	24		19
20	Contributions	(20,000)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,416)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,722)	27		24
25	Fund Raising, Advertising and Promotional	(15,011)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,537)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	288,218		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 288,218		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 249,681		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name HERITAGE MANOR-NORMAL
IDPH 0020281
Report Period Beginning: 01/01/01
Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(1,170)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(1,913)	35	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	(1,170)
9	**Non-Straightline Depreciation**	36,017	30	**Line 9**	0
10	**Interest and Other Investment Income**	(312)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	(1,139)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	33	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(787)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(11,254)	24	**Line 18**	0
20	**Contributions**	(20,000)	27	**Line 19**	(8,416)
21	**Owner or Key-Man Insurance**	0		**Line 20**	(15,750)
22	**Special Legal Fees & Legal Retainers**	(8,416)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(20,722)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(15,011)	20	**Line 24**	(11,254)
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	23	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(40,722)
29	**Non-Paid Workers**	0	0	**Line 28**	(72,198)
30	**Donated Goods**	0	0	**Line 29**	(72,198)
31	**Amortization Expense**	0	0	**Line 30**	36,895
32				**Line 31**	0
33				**Line 32**	(813)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	(1,971)
37				**Line 36**	35,782
38				**Line 38**	0
39				**Line 39**	0
40				**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(98,737)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,069	0	0	0	0	0	0	0	0	5,069	1
2	Food Purchase	(1,139)	0	0	0	0	0	0	0	0	0	0	(1,139)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,064	0	0	0	0	0	0	0	0	2,064	5
6	Maintenance	0	0	16,261	0	0	0	0	0	0	0	0	16,261	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,139)	0	23,394	0	0	0	0	0	0	0	0	22,255	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(13,706)		0	234,273	0	0	0	0	0	0	220,567	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	3,031	0	0	0	0	0	0	0	0	3,031	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(13,706)	3,031	0	234,273	0	0	0	0	0	0	223,598	16
	C. General Administration													
17	Administrative	0	0	44,935	0	0	0	0	0	0	0	0	44,935	17
18	Directors Fees	0	0	7,037	0	0	0	0	0	0	0	0	7,037	18
19	Professional Services	(3,416)	0	17,254	0	(373,285)	0	0	0	0	0	0	(359,447)	19
20	Fees, Subscriptions & Promotions	(15,798)	0	6,632	0	0	0	0	0	0	0	0	(9,166)	20
21	Clerical & General Office Expenses	0	0	243,985	0	0	0	0	0	0	0	0	243,985	21
22	Employee Benefits & Payroll Taxes	0	0	34,633	0	0	0	0	0	0	0	0	34,633	22
23	Inservice Training & Education	0	0	1,329	0	0	0	0	0	0	0	0	1,329	23
24	Travel and Seminar	(11,254)	0	9,446	0	0	0	0	0	0	0	0	(1,808)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,491	0	0	0	0	0	0	0	0	2,491	26
27	Other (specify):*	(40,722)	0	0	0	0	0	0	0	0	0	0	(40,722)	27
28	**TOTAL General Administration**	(71,190)	0	367,742	0	(373,285)	0	0	0	0	0	0	(76,733)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,329)	(13,706)	394,167	0	(139,012)	0	0	0	0	0	0	169,120	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	36,017	0	0	10,930	0	0	0	0	0	0	0	46,947	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(312)	0	0	(140)	0	0	0	0	0	0	0	(452)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	11,649	0	0	0	0	0	0	0	11,649	34
35	Rent-Equipment & Vehicles	(1,913)	0	0	24,330	0	0	0	0	0	0	0	22,417	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	33,792	0	0	46,769	0	0	0	0	0	0	0	80,561	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,537)	(13,706)	394,167	46,769	(139,012)	0	0	0	0	0	0	249,681	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning 01/01/01 Ending 12/31/01

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES - 405

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	10z Adjustment for Related Organizati	126,588	Greentree Therapy	100.00%	112,882	(13,706)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 126,588			$ 112,882	$ * (13,706)	14

Sum_6

-13706

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 5,069	$ 5,069	15	5069
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				2,064	2,064	19	2064
20	V	6	Maintenance				16,261	16,261	20	16261
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				3,031	3,031	26	3031
27	V	14	Program Transportatior				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				44,935	44,935	29	44935
30	V	18	Directors Fees				7,037	7,037	30	7037
31	V	19	Professional Services				17,254	17,254	31	17254
32	V	20	Fees, Subscription, Promotion				6,632	6,632	32	6632
33	V	21	Clerical & General Office Expenses				243,985	243,985	33	243985
34	V	22	Employee Benefits & Payroll Taxes				34,633	34,633	34	34633
35	V	23	Inservice Training & Education				1,329	1,329	35	1329
36	V	24	Travel and Seminar				9,446	9,446	36	9446
37	V	25	Other Admin. Staff Transportatior				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				2,491	2,491	38	2491
39	Total			$			$ 394,167	$ * 394,167	39	

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Print Preview

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Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				10,930	10,930	16	10930
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(140)	(140)	18	-140
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				11,649	11,649	20	11649
21	V	35	Rent-Equipment & Vehicles				24,330	24,330	21	24330
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 46,769	$ * 46,769	39	

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Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organizatio	$ 373,285	Heritage Enterprises, Inc.		$	$ (373,285)	15	-373285
16	V								16	
17	V	10a	Adjustment for Related Organizatior	231,244	Green Tree Pharmacy	100.00%	465,517	234,273	17	234273
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 604,529			$ 465,517	$ * (139,012)	39	

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Print Preview

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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6E

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6E

Print Preview

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Print Page 6F

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6F

Print Preview

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Print Page 6G

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6G

Print Preview

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Print Page 6H

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6H

Print Preview

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Print Page 6I

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6I

Print Preview

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Bill Froelich	Chairman of Boarc	Management	25.98%	28,488	10	0.20	Directors Fe	$ 1,265	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	28,488	10	0.20	Directors Fees	1,265	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	20.00%	28,488	10	0.20	Directors Fees	1,265	line 18, col 7	3
	Joe Warner	President	Management	2.50%	10,174	48	0.95	Directors Fees	452	line 18, col 7	
4	Bill Froelich	Chairman of Boarc	Management	25.98%	98,274	10	0.20	Salary	4,364	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	96,677	10	0.20	Salary	4,294	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	20.00%	81,684	10	0.20	Salary	3,628	line 17, col 7	6
7	Joe Warner	President	Management	2.50%	109,986	48	0.95	Salary	4,885	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.80%	59,861	50	1.00	Salary	2,659	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.31%	50,290	50	1.00	Salary	2,234	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.26%	48,677	50	1.00	Salary	2,162	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.17%	33,444	40	1.00	Salary	1,485	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.21%	31,835	50	1.00	Salary	1,414	line 17, col 7	12
13								TOTAL	$ 31,372		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT C [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	$ 71,961	$ 71,961	164	$ 5,069	1
2	2	Food Purchase	BEDS	2,328	23	0	0	164	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	164	0	3
4	4	Laundry	BEDS	2,328	23	0	0	164	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	164	2,064	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	164	16,261	6
7	7	Other	BEDS	2,328	23	0	0	164	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	164	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	164	0	9
10	11	Activities	BEDS	2,328	23	0	0	164	0	10
11	12	Social Service	BEDS	2,328	23	0	0	164	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	164	3,031	12
13	14	Program Transportation	BEDS	2,328	23	0	0	164	0	13
14	15	Other	BEDS	2,328	23	0	0	164	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	164	44,935	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	164	7,037	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	164	17,254	17
18	20	Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	164	6,632	18
19	21	Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	164	243,985	19
20	22	Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	164	34,633	20
21	23	Inservice Training & Educati	BEDS	2,328	23	18,866	0	164	1,329	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	164	9,446	22
23	25	Other Admin. Staff Transpor	BEDS	2,328	23	0	0	164	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	164	2,491	24
25	TOTALS					$ 5,595,265	$ 3,878,796		$ 394,167	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	$ 0	$ 0	164	$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	164	10,930	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	164	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	164	(140)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	164	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	164	11,649	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	164	24,330	7
8	36	Other	BEDS	2,328	23	0	0	164	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	164	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	164	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	164	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	164	0	12
13	42	Other	BEDS	2,328	23	0	0	164	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 663,885	$		$ 46,769	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		XX	Mortage	16000 plus int	01/15/99	$ 5,352,345	$ 4,852,441	01/15/06	variable	$ 372,556	1
2	LaSalle Loan Amortization		XX	Mortgage							6,124	2
3	Central Office Allocation		XX	Interest Income							(140)	3
4												4
5												5
	Working Capital											
6												6
7											0	7
8												8
9	TOTAL Facility Related						$ 5,352,345	$ 4,852,441			$ 378,540	9
	B. Non-Facility Related*											
10	Interest Income										312	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 312	14
15	TOTALS (line 9+line14)						$ 5,352,345	$ 4,852,441			$ 378,228	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	65,614	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	83,917	2
3. Under or (over) accrual (line 2 minus line 1).	$	18,303	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,113	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	106,416	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate ta

To Print this page only

Hold down Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-NORMAL COUNTY MCLEAN

FACILITY IDPH LICENSE NUMBE 0038281

CONTACT PERSON REGARDING THIS REP(CRAIG L. ATER

TELEPHONE (309)823-7135 FAX #:( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1429227003	HERITAGE MANOR-NORM.	$ 83,719	$ 83,719
2.		HERITAGE MANOR-NORM.	$ 0	$ 0
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,719	$ 83,719

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Numb HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1979	$ 60,687	1
2	Nursing Home				2
3	TOTALS			$ 60,687	3

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	164				$ 1,860,193	$		$	$	$	4
5					0						5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	64,594						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1992 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	A/C Basement Laundry			1996	6,741						26
27	Asphalt Repair			1996	21,401						27
28	Remodel/Painting			1996	1,912						28
29	Fire Alarm Repair/Replace			1996	8,069						29
30	Kitchen Floor/Backsplash			1996	1,395						30
31											31
32											32
33											33
34	C/O Allocation							10,930	10,930		34
35	Book Depreciation					245,630		282,580	36,950	2,966,555	35
36					3,316,757						36

*Total beds on this schedule must agree with page 2. See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

25 Page 12B
9 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tubes--Boiler	1997	12,279						37
38	Smoke Damper	1997	2,508						38
39	Perimeter Alarm	1997	3,364						39
40	Door Alarm	1997	3,909						40
41	Parking Lot Lights	1997	1,221						41
42	Fire Door	1997	2,146						42
43									43
44	Asbestos Removel	1998	985						44
45	Fire Daper	1998	4,589						45
46	Plumbing Maintenance	1998	3,285						46
47	HVAC Repairs	1998	2,139						47
48	Boiler Retubed	1998	5,720						48
49	Remodel Resident Rooms and Halls-materials	1998	739,117						49
50	Remodel Resident Rooms and Halls- Labor	1998	4,323						50
51	Remodel Resident Rooms and Halls-Professional Fees	1998	38,935						51
52									52
53	Moving Furnature Expense	1998	6,398						53
54	Computer Room Work	1998	896						54
55	Alzheimers Addition-Materials	1998	876,511						55
56	Alzheimers Addition-Labor	1998	516						56
57	Alzheimers Addition-Professional Fees	1998	162,266						57
58	Ventalation System-Materials	1998	54,231						58
59	Ventalation System-Professional Fees	1998	33,010						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,958,348	$ 245,630		$ 293,510	$ 47,880	$ 2,966,555	70

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,958,348	$ 0		$ 0	$	$ #######	1
2	Alzheimers Addition-Materials	1999	1,913,384						2
3	Alzheimers Addition-Labor	1999	16,393						3
4	Alzheimers Addition-Professional Fees	1999	43,955						4
5	Ventalation System-Materials	1999	2,591						5
6	Remodel Resident Rooms--Materials	1999	96,197						6
7	Remodel Resident Rooms--Professional Fees	1999	350						7
8	Patio Replacement	1999	3,700						8
9	WAN Room Renovation	1999	3,230						9
10	ALTA Survey	1999	5,488						10
11	PANIC Hardware	1999	1,941						11
12	Roof Work	1999	4,844						12
13	Boiler Replacement	1999	11,219						13
14	Garage Door	1999	985						14
15	West End Renovations-Labor	1999	2,184						15
16	Assisted Living Professional Fees	1999	1,843						16
17									17
18	West Wing Outlets	2000	8,485						18
19	Alzheimer Unit Flooring	2000	5,631						19
20	Accordian Door and Installation	2000	9,600						20
21	Air conditioning Units (2)	2000	1,240						21
22	Exterior Door Replacement	2000	6,095						22
23	Air conditioner -- Dishroom	2000	12,041						23
24	HVAC temp Control	2000	16,220						24
25	Mop sink and faucet (2)	2000	3,377						25
26	Clinical Sink	2000	847						26
27	Eye Wash Stations	2000	2,566						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,132,754	$ 0		$ 0	$ 0	$ #######	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,132,754	$ 0		$ 0	$	$ #######	1
2	West End Renovations-Labor	2000	9,940						2
3	West End Renovations-material	2000	7,991						3
4									4
5	Boiler Repair	2001	7,921						5
6	Code Alert	2001	6,248						6
7	Painting & Wallpaper Hallway	2001	2,714						7
8	Condenser	2001	3,203						8
9	Fire System Repair	2001	2,269						9
10	Sign	2001	3,266						10
11	Water Heater	2001	4,797						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,103	$ 0		$ 0	$ 0	$ #######	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,181,103	$ 0		$ 0	$	$ #######	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,103	$ 0		$ 0	$ 0	$ #######	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,181,103	$ 0		$ 0	$	$ #######	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,103	$ 0		$ 0	$ 0	$ #######	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,181,103	$ 0		$ 0	$	$ #######	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,103	$ 0		$ 0	$ 0	$ #######	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,051,513	$ 108,325	$ 107,392	$ (933)		$ 672,107	71
72	Current Year Purchases	21,184						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,072,697	$ 108,325	$ 107,392	$ (933)		$ 672,107	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,631,244	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 353,955	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 400,902	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 46,947	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,638,662	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 25,772 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		800		800
3	Classroom Wages (a)		800		800
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,600	$	$ 1,600
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,600			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 38,330	$		$ 38,330	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			8,846			8,846	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			65,706	1,407		67,113	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				465,679		465,679	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				929			929	13
14	TOTAL			$		$ 113,811	$ 467,086		$ 580,897	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

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st adj 4926
Ot adj -4594

drugs 234273

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$	1
2	Cash-Patient Deposits	15,108		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	604,562		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,524		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(239,678)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 399,816	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,333		13
14	Buildings, at Historical Cost	7,164,387		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,135,078		16
17	Accumulated Depreciation (book methods)	(2,251,129)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify):	24,495		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,254,164	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,653,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,059	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,108		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	282,670		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,317		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,113		32
33	Accrued Interest Payable	7,969		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 497,236	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,852,441		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,852,441	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,349,677	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,304,303	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,653,980	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 856,943	1
2	Restatements (describe):		2
3	audit Adjustment	96,906	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 953,849	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	350,454	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 350,454	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,304,303	24 *

*** This must agree with page 17, line 47.**

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